TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Trenton D. Weeks, D.C.

**Respondent Name**
ACE American Insurance Company

**MFDR Tracking Number**
M4-17-1652-01

**Carrier's Austin Representative**
Box Number 15

**MFDR Date Received**
February 1, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Dr. Weeks is Independent and not affiliate with any Insurance or Network. The services provided were a MMI/IR examination performed at the request of the injured employee and referred by the treating doctor. Accordingly, the Network Treating doctor made an appropriate referral for this service as a referral for a provider within the network would have been considered a disqualifying association."

**Amount in Dispute:** $350.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "CorVel asserts that out-of-network health care referrals must be approved by the certified health care network prior to services being rendered pursuant to TIC Sec. 1305.103. A treating doctor shall make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. To date CorVel has no record of an out-of-network referral to Trenton D. Weeks, DC for MMI/IR evaluation."

**Response Submitted by:** CorVel

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| February 9, 2016 | Referral Doctor Examination to Determine Maximum Medical Improvement & Impairment Rating | $350.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code Chapter 1305 governs the procedures for Certified Health Care Networks.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 196 – Non Network Provider
   - B5 – Pymnt Adj/Program guidelines not met or exceeded
   - 272 – Coverage/program guidelines were not met

**Issues**

1. When does the division have the authority to review a medical fee dispute involving a network claim?
2. Was network approval required for the disputed service?
3. Did Trenton D. Weeks, D.C. obtain network approval as required by Texas Insurance Code §1305.103?
4. Is this dispute eligible for medical fee dispute resolution as stated in 28 Texas Administrative Code §133.307?

**Findings**

1. Trenton D. Weeks, D.C. filed this dispute to the division seeking resolution under 28 Texas Administrative Code §133.307. The disputed services were denied with claim adjustment code 196 – "Non Network Provider." The authority of the Division of Workers' Compensation to apply the Texas Labor Code statutes and administrative rules for network claims is limited by the relevant sections of the Texas Insurance Code, Chapter 1305.

   Texas Insurance Code §1305.153(c) states that out-of-network care is subject to the Texas Labor Code if they are provided according to Texas Insurance Code §1305.006. Dr. Weeks must show that the services in dispute were done according to this statute for the division to have the authority to review the dispute.

2. Texas Insurance Code §1305.006 states that a network insurance carrier is only liable for out-of-network care when:

   - it is an emergency
   - if the employee lives in an area with no network care
   - if the treating doctor gets a referral approved by the network

   Dr. Weeks must meet one of these terms to be eligible for medical fee dispute resolution.

   Submitted documents do not assert or meet the definition of an emergency. Documentation also does not assert or support that the injured employee lives in an area with no network care. Dr. Weeks asserts in his position statement that he performed the examination "at the request of the injured employee and the treating doctor."

   Texas Insurance Code §1305.103(e) defines the terms for an out-of-network referral. Because submitted documents support that Dr. Weeks is an out-of-network doctor referred by the treating doctor, the services in dispute must have network approval.

3. Submitted documents do not support that the network approved the referral to Dr. Weeks. For this reason, the division finds that Dr. Weeks did not obtain network approval as required by Texas Insurance Code §1305.103.

4. The division finds that the disputed services do not meet the provisions of Texas Insurance Code §1305.006. For this reason, the services in dispute are not eligible for medical fee dispute resolution as stated in 28 Texas Administrative Code §133.307.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

**Authorized Signature**

| | Laurie Garnes | April 21, 2017 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.